Medicare's Experience with Medicine

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IN MEDICARE AS IN many other areas, California tops all other states in a number of important aspects. More Part A (hospital) and Part B (physicians') bills have been processed than in any other state. The expenditures per enrollee in both the hospital program and the medical insurance program have been the highest in the nation. In addition to the largest number of participating hospitals, California also has the largest number of Extended Care Facilities participating and represents 22.5 percent of the nation's total. Obviously, California is playing a major role in this new program and will have a definite influence on the course the program will follow in the future.

While I cannot from personal experience speak for the nation as a whole, I can speak for the seven Western States which are within my jurisdiction and can state that California has had some of the most complex and serious problems. However, had it not been for the many progressive innovations previously instituted by the medical profession in California, implementation of the program would have been many times more difficult.

Such things as the California Medical Association's *Relative Value Studies,* organized utilization review programs in hospitals and medical societies, the program of CMA medical staff surveys of hospitals and many other pioneering efforts have provided important foundations for Medicare, not only in California but nationwide. The strong cooperation from the medical community has contributed immeasurably to the job I and my staff could do during the first difficult years. Names of physicians that come readily to mind in this respect are Carl E. Anderson, Joseph F. Boyle, Jean F. Crum, Roberta Fenlon, Donald C. Harrington, George K. Herzog, Jr., Albert G. Miller, John G. Morrison, William F. Quinn, Pierre Salmon, Marvin J. Shapiro, Samuel R. Sherman, Malcolm C. Todd, Malcolm S. M. Watts, Harry Weinstein, Dwight L. Wilbur, and Richard S. Wilbur. They and many helpful others have been and continue to be involved not only regionally but on the national scene, and the great assistance they have supplied both in formal and informal meetings and consultation, surely made it possible for us to avoid many serious problems. The massive job in California still has "kinks" to be worked out but with continued cooperation of the physicians and others in the health field and as the program becomes better understood, there is in my judgment no reason why California cannot rank first in quality as well as first in quantity. As it has in other things the medical community in California can set an example to the nation on ways and means to administer this program more efficiently and economically.

As the Medicare Program only recently celebrated its second anniversary, it is timely to review the program up this point—including some of the problems we have had and how we have worked them out—and to consider where we are going.

A few statistics indicate the scope of the program. As of 1 July 1968, 19.7 million persons in the nation aged 65 and over were covered under the basic hospital insurance part of Medicare. Of this number, approximately 18.6 million, or 95 percent of the total, have enrolled in the voluntary medical insurance part. In California about one and three-quarter million are covered under hospital insurance with over one and a half million enrolled in Part B medical insurance.

In its first two years of operation the program nationally paid 8.4 billion dollars (6.3 billion dollars under the Part A hospital insurance program and 2.1 billion dollars under Part B medical insurance). Current statistics on a state or local

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basis are hard to come by, but a measure of the scope of the program in California is that every working day the California carriers (Occidental and California Blue Shield) receive about 21,000 Part B claims from beneficiaries, physicians and suppliers of other covered medical services.

A fortunate outgrowth of the program has been the impetus for further development of the concept of alternate levels of care. Until now, most insurance programs have considered the payment of hospital benefits the ultimate in coverage. Now Medicare has provided coverage in the outpatient hospital area, the Extended Care Facility (ECF), the Home Health Agency (HHA), and the hospital itself. Thus the program has made it easier for physicians to choose the level of care most appropriate to the older patients' medical needs.

For example, 4.2 million bills were paid during the first two years for outpatient hospital services, and 485,000 home health care plans were set up for older people to receive visits from visiting nurses, physical therapists and other health specialists. Since 1 January 1967, there have been 644,000 admissions of Medicare beneficiaries to ECF's. In California more than 250,000 ECF bills have been processed. Bear in mind that before this program was begun the ECF was a virtually nonexistent commodity in the health market, while today in California 888 Extended Care Facilities are participating in the program.

In commenting on the program's second anniversary, Robert M. Ball, Commissioner of Social Security, noted: "The successful operation of Medicare would not have been possible without the cooperation and hard work of thousands of people, both inside and outside the Federal Government."

What the commissioner referred to was that the Government has not acted alone. Involved in the operation of Medicare, along with the Federal Government, are 123 private insurance organizations—Blue Cross and Blue Shield plans and commercial insurance companies who receive and pay Medicare bills under contract with the Federal Government; 6,900 participating hospitals; 4,700 participating ECF's; 2,100 home health agencies; 2,550 certified independent laboratories; and agencies of the 50 different states.

California's health care delivery system is the largest in the nation. Three carriers, California Blue Shield, Occidental and the Travelers (servicing 52,000 railroad retirement beneficiaries) handle the majority of the Part B claims. In addition about 73,000 beneficiaries are members of six group practice prepayment plans which deal directly with the Social Security Administration. The 595 participating hospitals, 888 Extended Care Facilities and 95 Home Health Agencies work with six Part A fiscal intermediaries—Blue Cross of Oakland, Blue Cross of Los Angeles, Mutual of Omaha, Aetna, Travelers, and Kaiser. In addition, the Social Security Administration services directly the State Mental Hygiene hospitals plus several other providers.

The Use of Familiar Frameworks

The huge cooperative effort previously noted has come within the framework of what the medical health services have been familiar with in the past. In other words, this legislation has maintained the separation of government and health care delivery except in matters of quality standards and in the methods of payment. For years the Public Health Service and the medical profession have cooperated in the furtherance of quality standards in the delivery of medical care. The third party payments system has been present for a good number of years. In these two areas Medicare built on previous conditions and improved upon them.

"Medicare enters its third year on a sound administrative basis," Commissioner Ball said. "With experience and the close cooperation of all involved, problems that arose with the launching of the massive program have been eased, and the entire administrative process is under continuous study to assure that it operates at maximum efficiency." The problems that Commissioner Ball referred to were not unexpected, considering the magnitude of the program, the large number of divergent organizations involved in its administration and the newness of some of its concepts.

What have been some of the problems referred to and what has been done to eliminate them?

One problem has been that carriers have had heavy pile-ups in the medical insurance claims processing operation during a large part of the first two years of the program. One of the major factors contributing to this accumulation was the lack of understanding of the claims procedure on the part of beneficiaries. Although now diminishing, this problem remains despite all the informational efforts which preceded the start of Medicare and which still continue. Even now California Blue

Shield receives more than a thousand claims a day containing incorrect health insurance claim numbers.

Another factor which required consideration was the need to familiarize physicians with the information needed by the carriers to determine and pay reasonable charges for services performed. When the Request for Payment Form—the 1490—was first developed with considerable assistance from individual physicians and the AMA, we thought it was a relatively simple form to complete. We have made improvements in this form in an attempt to ease the claims process.

At the same time, we have been conducting comprehensive review of the performance of carriers and intermediaries with regard to their organization, personnel management, claims processing, utilization review, and professional relations. Our purpose is to find out where improvements might be made and to assist the carrier and intermediary in discharging their obligations to both the beneficiaries and the providers of services. Review teams from the Bureau of Health Insurance make regular on-site surveys of administrative and operational activities of the third parties to help meet problems of this kind.

In its approach to all problems the Social Security Administration has used not only its own personnel but leadership of medical and paramedical organizations for guidance. It has used the Public Health Service to aid particularly in the establishment of quality standards. It has also maintained regular and active liaison with physicians in an attempt to analyze the problems and bring them to agreeable solutions. All of this has been done so that the viewpoint of the physicians, the providers and the beneficiaries themselves may be properly considered.

The Social Security Medicare legislation, and the regulation and administrative guidelines that have followed, have all been directed toward keeping the Medicare patient in the mainstream of medical care. This goal has been paramount even though the principle of non-interference with the patient-physician relationship on occasions has made the program more complex than it might otherwise have been. For example, payment of physicians' services on a "usual and customary" rather than fee-schedule basis has increased administrative complexities. However, this mechanism, which has such universal physician acceptance, has been one of the key provisions designed to insure high quality medical care for the Medicare patient, and undoubtedly is a cornerstone in the program.

Efforts to Simplify Procedures

The effort to streamline procedures and to cut down paperwork and processing time has been continuous. As problems have been identified, steps have been taken to effect simplification. Some of the time and trouble savers that have been effected are:

- Elimination of date of birth from claim form.
- Dropping physician address.
- Obtaining patient signature only on hospital's own admission forms.
- Grouping outpatient diagnostic procedures instead of listing separately.
- Omitting signature where patient does not visit the hospital. (For example, when specimen is sent to the hospital laboratory.)
- Extension of optional method of billing to hospital-based physicians in addition to radiologists and pathologists.
- Obtaining a blanket assignment from an inpatient for all physician services billed by the hospital during confinement and for all outpatient services billed by the hospital for a stated period up to a year.
- Allowing a physician or clinic to take a blanket assignment for services within the calendar year.
- Eliminating need for California Medi-Cal recipients to sign Medicare billing forms. (This was done by accepting the one-time assignment statement on the reverse of the Medi-Cal identification card.)
- Accepting a physician's stamped signature on Medicare billing forms.

Some problems which became apparent during the program's first year have been the subjects of amendments to the law which were enacted by Congress in late 1967. One problem solved by amendment was the requirement of physician certification of need for admission of Medicare patients to general hospitals and also of the medical necessity for outpatient services. When it became clear that this provision was difficult for many physicians to live with, the Social Security Administration took cognizance of the problem and legislation was introduced in 1967 to eliminate the requirements.

Under another amendment, patients who wish

to pay physicians directly for Medicare services may be provided with the money they need for the purpose on presentation of an itemized bill. Heretofore a receipted bill was required, which meant that the patient had to be out-of-pocket for the time between payment and reimbursement.

While philosophical differences may still exist concerning the program, it is in the main acknowledged that the problems of Medicare are a joint responsibility of government and medicine. Physicians recognize this, just as government representatives recognize that supplying medical care, determining what kind of care is medically necessary and setting acceptable levels of care must remain the physician's responsibility.

Utilization Review

Utilization review also causes problems. The law requires hospitals and ECF's to set up utilization review committees. Utilization review is primarily a function of the medical profession and it requires determinations of not only medical necessity but also whether the most efficient use of available facilities is being made. The effectiveness of utilization review committees has been quite uneven, particularly in the newly established and little understood Extended Care Facility.

Recognizing the problem—for it took the leadership in establishing utilization review as an educational tool as much as 15 years ago—the AMA called a meeting at Houston in the latter part of 1967 to explore pertinent questions. The AMA has also published a handbook for medical societies to use as a guide in helping ECF's secure adequate medical staff and perform the utilization review functions.

The pioneering efforts by the California Medical Association in setting up review mechanisms are well known. Its manual, *Guidelines for Utilization Review,* is used as a guide in many other states. With the medical profession, representatives of the Social Security Administration are currently attempting to solve some of the problems faced in utilization review in various manners: Experimental regional utilization review practice, increasing educational output to the profession, statistical analysis of lengths of patient stays, and communication with the fiscal intermediaries in order to learn the problems in all parts of the country. In California the response of Medicine has been quite impressive with many of the county medical societies currently providing utilization review for ECF's.

Another difficult problem encountered has been determining the level of care to be supplied to Medicare patients in Extended Care Facilities. In the past, all non-covered care in an extended care facility was identified as "custodial care," which by law is specifically excluded. This was confusing since "custodial care" has different meanings for different professions. Therefore, the term *non-covered* care has been substituted. It now applies to any level of care that is less intensive than *extended care,* which is covered by the law. New guidelines were issued to intermediaries, and they held workshops in August and September with all their extended care facilities. A flyer, "When Care Furnished to ECF Patients Can Be Covered by Medicare," was mailed to physicians. The new guidelines provide for prompter decisions on coverage so that patients and their families will not find themselves in debt for stays they thought would be covered. It is hoped that these actions to bring about a clearer understanding by the patient, the physician and the facility as to just what constitutes non-covered care will reduce the problem of retroactive denial of coverage which has plagued ECF's.

The Social Security Administration has also been taking a very careful look at the Medicare provisions for reimbursing those who provide services. As the readers of this journal no doubt know, institutional providers of services—that is, hospitals, extended care facilities and home health agencies—are reimbursed on the basis of "reasonable cost" of services, while reimbursement for physicians' services and other medical services is based on the "reasonable charge" for such services. In light of the continuing increases in the cost of health care services, the provision in the 1967 amendments for incentive reimbursement experimentation will be directed toward development of incentive to efficiency and economy without adversely affecting the quality of services provided. This presents an opportunity for representatives of health care suppliers to offer study proposals and to volunteer to participate in them. However, such testing can only be carried out with the full cooperation of hospitals, physicians and their organizations.

A discussion of the beginnings of Medicare, its problems and the progress toward solutions leads

logically to the question, "Where does the program go from here?"

We recognize that program evaluation is a continuous process. I hope that I have been able to make it clear that two-way communication and cooperation of the Federal Government, the medical community and the providers of service have been the key to identifying problems and finding ways to solve them. The Social Security Administration welcomes and is responsive to suggestions for improving the program.

No one knows better than the physician what the program has meant to his elderly patients, not only to those who have had serious illness but those who have lived in fear of the financial burden they might have to face. May I close this article with an expression of deep and heartfelt appreciation to the California medical community for the cooperation it has given; and may I quote from three of the many letters we have received from your patients and our beneficiaries for whom the program was designed:

"There are no words full enough to express the gratitude both my mother and I feel for your sustained help in the pension and the full help of Medicare. You in effect actually gave mother a year of life, not vegetation, and eased the fear of insecurity."

"After a remarkably healthy life, I have fallen victim to cancer of most serious proportions. The outcome is still doubtful, but I am receiving the best treatment now known. My resources are limited, but with the aid of Medicare, I shall be able to have necessary care and to continue the battle without the added worry of finances. I simply must say, 'Thank you'."

"My husband was well on his way to recovery when he had a kidney and bladder infection which took him back to the hospital. We are very grateful for the benefits he has received. It means just the difference between getting along fairly well or going straight plain broke. Accept our thanks."

DISTINGUISHING BETWEEN FORMS OF HEPATITIS

"In the protracted form of viral hepatitis, the onset invariably is acute; and the initial lesions, except possibly for their distribution, are identical with those in acute viral hepatitis. Characteristically, if treatment is begun before the appearance of advanced hepatocellular failure or cirrhosis, the disease is remarkably—although not invariably—responsive to corticosteroid therapy. Even in patients who are untreated, the lesions are not necessarily progressive, and indeed may heal without residuals, or occasionally heal with cirrhosis that remains inactive.

"In contrast, chronic active hepatitis (at least in my experience) invariably has an insidious onset; and usually by the time the disease becomes clinically overt, the lesions already show evidence of chronicity. In my experience I've never seen the early lesion. It is invariably associated with varying degrees of fibrosis and indeed usually with cirrhosis. Characteristically, the disease is progressive and often is relatively resistant to corticosteroid therapy. At best, such therapy may suppress the clinical and biochemical manifestations of the disease, but rarely—if ever—induces a sustained remission without treatment or actual cure."

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